Page 1:

Applicant's Name

First Name & Last Name

Race

White
African American
American Indian
Asian
Alaskan Native
Native Hawaiian/Pacific Islander
Hispanic

Marital Status

Single/Never Married
Married
Divorced
Co-habituating
Widowed
Separated
Unknown

Evaluation Location

Indicate the location of the individual at the point of interview or contact.

Legal Guardian

A Court appointed full guardian. This would not include POA's, financial representatives, etc. It is acceptable to list other representatives, but specify the relationship to the applicant.

ADA Accommodations

Americans with Disabilities Act. This would include adaptive devices, interpreters, or any assistive devices needed to perform the evaluation.

Referral Information

Include area codes with phone numbers.

Type of Referral

This should be consistent on all evaluations. However, there are instances when dually diagnosed residents require an update for only one diagnosis. Please indicate which by checking the appropriate box.

Mental Illness

An individual who meets the criteria on the MAP-409 for a serious mental illness.

Intellectual Disability

An individual who meets the criteria on the MAP-409 for intellectual disability.

Related Condition

A condition similar to intellectual disability usually caused by a developmental delay during childhood (prior to age 22). See the MAP-409

for conditions that might be indicative of a related condition. ***Note that the individual would meet criteria for substantial functional limitations in three or more of the listed major life activities prior to age 22.***

Dual Diagnosis

An applicant or resident who meets the criteria for both mental illness and intellectual disability or related condition as identified on the MAP-409.

Type of Assessment

New Admission: An individual who is experiencing an episode of delirium related to a physical condition that is expected to resolve within fourteen (14) days.

Re-Admission: An individual is a re-admission of he/she was re-admitted to a NF from a hospital to which he/she was transferred for the purpose of receiving care. Re-admissions are not subject to Level I screening, but may be subject to a Subsequent Review if the person has experienced a significant change in condition as defined in 3.4 of this manual.

Hospital Exemption: An individual who currently resides in a hospital whose physician has completed the thirty (30 day exemption form stating that nursing facility is needed for management of the problem for which the individual was hospitalized. This stay is expected to be thirty (30) days or less.

Provisional Admission: A request for a Level II PASRR should be initiated when it appears that the individual admitted under this provisional admission will not be discharged within the fourteen (14) days. The nursing facility will not be eligible for reimbursement after the fourteenth (14th) day of the admission date until a PASRR determination is made authorizing nursing facility level of care. There are two (2) categories of provisional admissions.

Delirium – An individual who is experiencing an episode of delirium related to a physical condition that is expected to resolve within fourteen (14) days.

Respite – An individual whose caregiver has requested admission to a NF for not more than two (2) weeks (fourteen (14) days) of relief from caregiver responsibility.

New to PASRR: An individual who resides in a nursing facility but has not previously had a Level II performed. This is usually someone who was admitted without adequate information to document the existence of a mental illness or intellectual disability/related condition diagnosis prior to admission.

Initial Resident Review: An individual who was admitted to the nursing facility without a Level II having been performed prior to admission. This could include a hospital exemption, one of the provisional categories (delirium and respite), or an individual who did not appear to meet criteria upon admission, but new information becomes available or circumstances change.

Significant Change of Condition: A current resident of a NF (who has previously had a Level II evaluation) and experiences a change in physical or mental functioning that will affect that individual's need for either continued nursing facility stay as the least restrictive

environment, or might now need specialized services and previously did not.

Subsequent Review: Significant change in condition line should be documented as the date the MDS triggered a significant change. *The date of admission to the nursing facility is the initial admission date to the facility.*

Informational Sources

Directions for this component are fairly self-explanatory. It should be noted; however, that under record/document review that when previous Level II evaluations are used as an informational resource, this should be documented here

Page 2: **Psychiatric Hospitalization History**

The PASRR manual documents that release of information is not needed for applicants applying to a Medicaid certified nursing facility. Consult with evaluators from other regions when evaluating someone from a different region as they might have a working relationship with the psychiatric facilities in their regions and be able to obtain this information for you. Interview family members and the applicant. If exact dates are not known, document approximated dates.

Community Based Treatment

Interview the applicant and family members. Contact evaluators from other regions when indicated. Please document treatment in both the public and private sector, including outpatient and Community Supported Services.

History of Cooperation

Regarding previously recommended treatment

Referral Diagnosis

This should be the diagnosis given at the initial referral contact, not the diagnosis you arrived at based on the MSE or additional documentation. These might frequently be different.

Mental Status Assessment

Complete by indicating the appropriate option. If no appropriate options are listed, make note of this in the comments section. Please complete each category within a section and not place one check mark for the total section.

Comments

List diagnostic history, recent improvement or decline of SMI, describe current psychiatric symptoms (mood, orientation, cognition, thought content, etc.)

Page 3: **Tools for MSE**

Indicate at the top of Page 3 whether the Mini Folstein or another tool was used to complete the Mental Status evaluation.

Dementia/Organicity

Note whether it is a documented diagnosis or based on the MSE performed during the evaluation. If there is a documented diagnosis, but the results of the MSE performed for the evaluation do not substantiate this, comment on this line.

Axis I

Indicate the current diagnosis believed to be correct based upon MSE and documentation. If there is a disparity between the diagnosis contained in the attached documentation and the current correct diagnosis, please indicate this and why this is clinically indicated on the Other Comments line.

Axis II

As with the mental illness diagnosis, document the current clinically indicated diagnosis. Substantiate any disparity in diagnoses found in attached documentation and contained in the evaluative report. For intellectual disability diagnoses, a psychological evaluation or: "Supporting documentation" to validate the ID/ or related condition diagnosis as specified in section 3.2.

Axis III

Document the currently active diagnosis first, and the historically related diagnosis last. Try to include all diagnoses if possible.

Axis IV and Axis V

These may not always be relevant for PASRR purposes, but document these when possible. If unattainable or not applicable, defer theses diagnoses. If dementia is substantiated as the primary diagnosis affecting the applicant's mental status, document this on the *Other Comments* line and indicate that it is not necessary to complete additional components of the evaluation based on this impression.

IQ Level Document IQ level if available. Include date obtained.

Other Comments

Explain if there is a disparity in the current diagnosis versus the referral diagnosis

Medication History

Please list current medications and previous psychotropic medications. Please always include dosage frequency and reason. If a complete current list of medications is attached, this (***see attached medication list***) may be noted on the line for ***currently prescribed medications***.

Previous Psychotropic Medications

List known medications prescribed in the past. Note that sometimes medications previously prescribed will be contained in medication allergies

Mask or Mimic Psychosis

List medications currently prescribed that have potential to affect mental status by masking or mimicking psychosis/depression.

Self-Management of Medication

Check appropriate option. If individual is residing in a NF at the time of the evaluation and takes medications as offered, document Not Applicable in this component. Please complete for new admissions.

Side Effects

Note any physical indications of a drug induced movement disorder here. Also note complaints that the individual has that could be medication related.

Allergies

List allergies if available from documentation or the individual's report. Document that information is unavailable if this should be the case.

Drug Abuse

Note abuse of alcohol and/or non-prescribed medication, if available. If not available from records or individual's report, document this.

Page 4: **Reason for Placement**

This is not specific nursing facility services that the individual will need, but the reason nursing facility placement is being requested. Please note that this section is requesting identification of changes in status and/or living situation that contributed to the request for placement.

Family and Friends

List family members and friends, especially those interviewed for the evaluation purpose. Include area codes with phone numbers. Please list names and relationship to applicant.

Communication Skills (a)

Check the appropriate option. If impaired, note what action has been taken to overcome this (i.e., communication board, physical cuing, changed vocal intonation, written communication, interpreter, etc.).

Communication Skills (b)

Rank each activity of daily living listed by assigning a number 1-4.

Communication Skills (c)

Add comments if the rank does not provide enough information to clearly address functioning level.

Base Level of Care

Circle the applicable criteria for meeting Medicaid's current level of care. A person must meet at least two to be admitted to a nursing facility under any circumstances

Additional Criteria to be Considered

If the person is a danger to self or others or their care needs (related to behavioral health) are beyond capacity for nursing facility to meet, the person can meet Medicaid level of care but still not be appropriate for nursing facility admission.

Patient Status

Considering the diagnosis, care needs, services and health personnel required to meet these needs; their needs might be better met in personal care, family or foster care home, or residential care setting.

Page 5: **Impact of Medical on Functioning**

Describe how the current medical conditions impact functioning (versus mental conditions)

Describe Nursing Facility Services Needed or Receiving

Note the directive “Be very specific”. Possibilities include, but are not limited to; monitoring of vital signs (blood pressure, pulse, respiration), physical therapy, occupational therapy, speech therapy, respiratory therapy, administration and monitoring of medications, laboratory tests for various reasons, including medication levels, accurate diagnosing, monitoring of nutritional status, including recording of intake and output amounts or monitoring of a specialized diet, specific skin treatments, monitoring of indwelling or external catheter, gastric tube, IV site, wound healing or other specific MD ordered treatments.

Comprehensive History and Physical Data: Source of Data

Refer to the specific document that was used as the basis for your determination of level of care. If there have been changes in the individual’s condition since the document was completed, document the change in the appropriate body system component. If the document is complete and current you may refer to it by noting, “See attached document: If performing an evaluation in a medical setting and the discharge summary is not yet available, copy initial systems review and some recent physician progress notes, as the initial systems review often does not yet contain the current medical issues.

Abnormal Findings

Note abnormal findings that need further assessment or have potential to affect the individuals overall needs here.

Referral to Agency or Person

If referred to an outside agency for needed medical information, please note the agency or person here.

Level of Care Certification

This is sometimes very difficult to obtain, and if this is the case, note, “Not obtained” on this line. This is “n/a” for all pre-admissions.

Pages 6-7: Either refer to an attached document or arrange for completion by the professional who performed the systems review. Please note: the physical exam must be completed by a physician, registered nurse, or a physician's assistant. If not performed by a physician, he/she must review and concur with conclusions.

Page 8: **Review of Findings**

This is the summary that is forwarded to the individual's MD, so a brief but thorough summary is indicated for each component. Please do not leave any sections blank or reference another section of the evaluation. Documentation is required.

Page 9 **Recommendations**

Check the appropriately indicated box.

Specialized Services Plan: Please complete this section or place N/A in the blank if it is not applicable.

Disposition: Check the appropriately indicated box.

Continue in Process: All individuals who have had Level II evaluations will continue in the process unless they have a primary diagnosis of dementia. If this is the case, document this here.

Page 10 **Time Frames**

Note that the date referral received is the date that a decision was made that the referral requires a PASRR evaluation. The date verbal was given is the date a determination was made regarding level of care and specialized services and communicated to the nursing facility (usually the date of the mental status assessment). Date sent is the date the evaluation was mailed to the nursing facility.

Page 11 **Interpretation of Findings**

Indicate to whom the findings were sent by checking one of the three options. Be sure the evaluator signs this page. Fax completed Level II evaluation with Interpretation of Findings to DBHDID 502-564-2284.